

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION****PART I: GENERAL INFORMATION**

Requestor's Name and Address:  LES BENSON MD PA 1220 GUNNISON WACO, TX 76712	MFDR Tracking #:	M4-09-1531-01
Respondent Name and Box #: <b>19</b>  SENTRY INSURANCE A MUTUAL CO		

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary: "I performed a Designated Doctor Examination on Mr. Coleman on 6/23/08. I submitted a bill for this service 7/21/08. I did not receive an EOB or payment within sixty days. I sent a request for reconsideration on 9/28/08. I received an EOB denying payment because lack of NPI, which was on the CMS 1500, box 24 J. I have included copies of the original bill (with conformation {sic}), request reconsideration (with EOB) and EES 14."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$875.00
3. CMS 1500s
4. EOBs

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: The Carrier did not submit a position summary.

Principle Documentation:

1. Response to DWC 60

**PART IV: SUMMARY OF FINDINGS**

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
6/23/08	99456-W6 See Rule 134.204	1 thru 14	\$500.00
6/23/08	99456-W7 See Rule 134.204	1 thru 14	\$250.00
6/23/08	99456-W9 See Rule 134.204	1 thru 14	\$125.00
<b>Total:</b>			<b>\$875.00</b>

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and 28 TAC Section 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*. The Guideline shall be effective for workers' compensation specific codes, services and programs provided on or after March 1, 2008.

1. These services were denied by the Respondent with reason code 1-(206) National Provider Identifier- missing. State regulations now require that the Billing Provider NPI# must be included on the billing statement. Please resubmit bill for processing with a valid NPI# included.
2. The information the Requestor submitted in this dispute is reviewed. The Provider was asked to perform a Division ordered Designated Doctor Examination per the Texas Department of Insurance Division of Workers' Compensation EES-14 form submitted in this dispute. The Provider was asked to determine the extent of the employee's compensable injury, determine whether the employee's disability is a direct result of the work related injury and other (similar issues) disability from May 9, 2008 to the present.
3. The Division contacted the Carrier on 2/2/09 asking for information referencing the missing NPI#. The Division has documentation from the Carrier stating that the NPI # needs to be in both Box 32 and 33 of the CMS 1500 billing form. The Provider was contacted by the Division on 2/2/09 explaining that the Carrier cannot process the bill as the NPI# has to be listed in both Box 32 and 33 on the CMS 1500. Review of the Provider's bill lists the NPI# in Box 24J.
4. The Centers for Medicare and Medicaid Services (CMS) professional billing form, the CMS-1500 is required for health claims (bills) submitted on or after July 1, 2007. While the National Provider Identification number (NPI) is not "required" in every NPI field on the paper claim, the Division encourages health care providers to use the appropriate NPI number to help ensure timely processing of claims and prompt payment.
5. Field 32a is listed as "optional" for supplying the NPI of provider/location where the health care was rendered or services were provided. Field 33a is listed as "required" for supplying the NPI of the individual health care provider who rendered the health care or supervised an unlicensed individual providing the health care. If the service being billed for is an interdisciplinary program as defined in the medical fee guideline, enter the information referenced above for the approved supervisor.
6. The Division has not heard from either the Requestor or the Carrier in regard to this dispute. The Division contacted the Carrier on 11/3/09 and spoke with the Beth Roeder who confirmed that the NPI denial was no longer an issue. She stated there was a new issue of a missing modifier. The Division did not have this new denial so the Carrier was asked to submit it. The Provider was also contacted on 11/3/09 by fax asking if a new bill had been submitted. The Provider responded back by fax on 11/4/09 stating payment had not been received but did not answer the Division's question if a new bill had been submitted. The Provider was contacted again by fax on 11/9/09 and to date the Provider has not responded to the Division.
7. The Division received the new denial on 11/3/09 by email which has an audit date on the explanation of benefit (EOB) of 3/3/09. The Division received the medical fee dispute on 10/20/08. This would make this a new denial after the Division received the medical fee dispute.
8. Rule 133.307(d)(2)(B) states: Responses to a request for MDR shall be legible and submitted to the Division and to the requestor in the form and manner prescribed by the Division. Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier. The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.
9. The EOB the Carrier submitted has an "RM" modifier attached. The Division emailed Beth Roeder with the Carrier to ask about the "RM" modifier and response received stated it is an internal modifier to alert their system to price as range of motion performed. The Provider was not asked to perform an MMI/IR evaluation which would address range of motion.
10. The Division received further correspondence from Beth Roeder with the Carrier via email on 11/13/09 stating that the "W5" modifier is the first modifier to be applied when performed by a designated doctor and that none of the lines are billed with "W5" so the charges are denied for required modifiers.
11. Rule 134.204(n)(20) states: The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement. The Provider was not asked to perform an MMI/IR evaluation.

12. Under the same Rule 134.204(n) subsection (21) states: W6, Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury. The Provider did perform an extent of injury determination. Subsection (22) states: W7, Designated Doctor Examination for Disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury. The Provider did confirm the injured employee's disability directly resulted from his work duties. Subsection (24) states: W9, Designated Doctor Examination for Other Similar Issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues. The Provider was asked to address other (similar issues) – disability from May 9, 2008 to the present which the Provider did verify.
13. Rule 134.204(i)(2)(A-C) states: The following shall apply to Designated Doctor Examinations. When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.
14. Therefore, for the reasons noted above, reimbursement to the Provider is recommended.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311  
28 Texas Administrative Code Section. 134.1  
Texas Government Code, Chapter 2001, Subchapter G  
134.204 and 133.307

#### **PART VII: DIVISION DECISION AND ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$875.00 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

#### **ORDER**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Auditor  
Medical Fee Dispute Resolution

11/17/09  
\_\_\_\_\_  
Date

#### **PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**